The hospital outpatient prospective payment system

Presentation to Senate Committee on Finance staff

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Overview

- What are outpatient services and how much is spent on them?
- How does the payment system work?
- What are the current issues?

Outpatient services

- Covered by the outpatient PPS
  - Outpatient surgery and procedures
  - Emergency visits
  - Diagnostic tests
  - Clinic visits
- Not covered by the outpatient PPS
  - Clinical lab
  - Prosthetics, orthotics, durable medical equipment (excluding implantable devices)
  - Ambulance
  - Physical, occupational, speech therapy
  - Screening mammography

Overview, 2001

- 22.2 million beneficiaries served
- 4,350 providers
- Total spending for all outpatient services: $18.4 billion (8% of Medicare total)
- Total spending for outpatient PPS: $16.3 billion (6% of Medicare total)
- Outpatient payments = 14% of overall Medicare payments to hospitals

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Expenditure growth

- All outpatient services: Average annual growth of 6.5 percent, 1991 to 2001
- Outpatient PPS: Projected annual growth of 8 percent, 2002 to 2005

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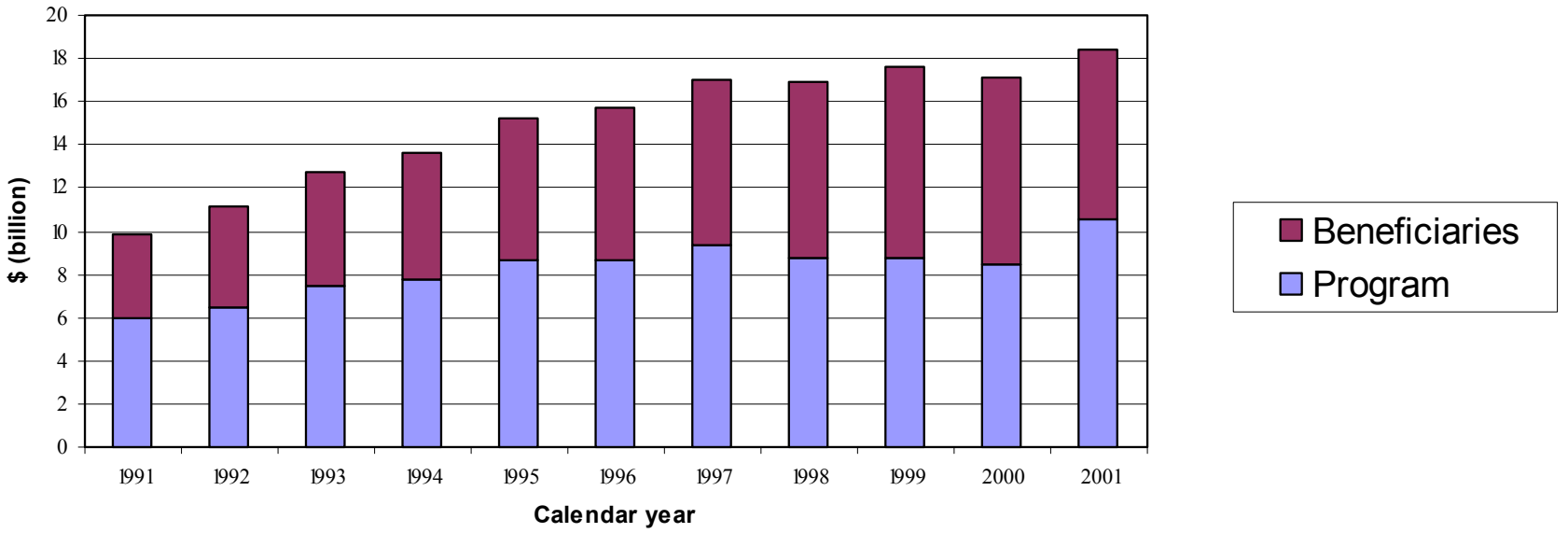
Spending trends

Figure 1. Spending on all hospital outpatient services, 1991-2001



Note: Spending includes both services covered by the outpatient PPS and those paid on separate fee schedules or on a cost basis.
Source: CMS, Office of the Actuary

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Outpatient PPS

- Funded under Part B
- Historically, payment was lesser of costs or charges or a blend of fee-schedule rate and costs (ambulatory surgery, some radiology and diagnostic services)
- Prospective payment system implemented in August 2000

Elements of the payment system

- Unit of payment – the individual service
  - Can bill for multiple services on same day
- Classification system – ambulatory payment classification (APC) groups
- Relative weights
  - Single value for each APC that reflects relative costliness of that service compared to others, based on median costs
  - Exception: New technology APCs
- Conversion factor – transforms relative weight into payment

Ambulatory payment classification groups

- Mixture of large bundles (ambulatory surgery) and single services (x-ray)
- Grouped into:
  - Surgery and other procedures
  - Clinic and emergency visits
  - Ancillary services (e.g., diagnostic services)
  - Separately billable drugs
  - New technologies
  - Pass-through devices/drugs
- In 2003, about 570 APC groups, with national payment rates ranging from less than $1 (immune globulin) to over $20,000 (implantation of cardioverter-defibrillator)

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Outpatient services with highest expenditures, 2001

APC	Title	Share of payments
0283	Level II computerized axial tomography	8%
0246	Cataract procedures with lens insert	6
610, 611, 612	All emergency visits	6
600, 601, 602	All clinic visits	4
0260	Level I plain film except teeth (x-ray)	4
0143	Lower gastrointestinal endoscopy	3
0286	Myocardial scans	3
0284	Magnetic resonance imaging	3
0268	Echocardiogram	3
0080	Diagnostic cardiac catheterization	3
TOTAL:		43%

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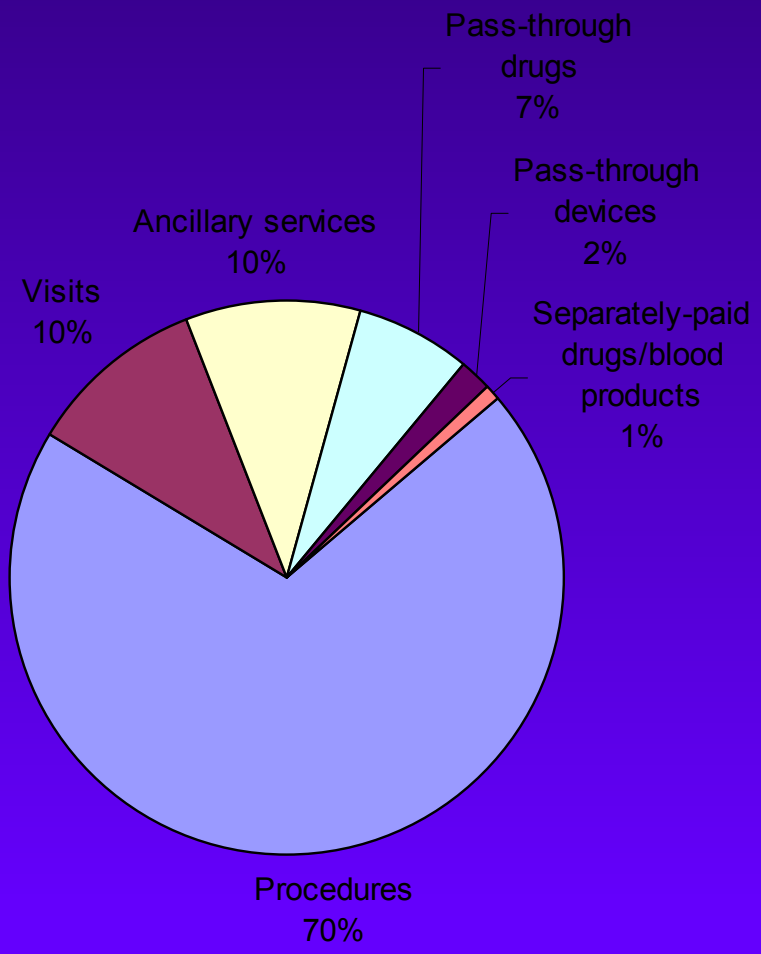
Spending by type of service, 2001



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Base payments

- Base payment covers the hospital's costs of providing the service (physician paid separately)
- Base payment built on total cost-based payments – including coinsurance – in 1996
- 60 percent of payment is adjusted by the hospital wage index
- Updated annually using hospital market basket

Adjustments to base payments

- Pass-through payments
- Outlier payments
- Transitional corridors

Pass-through payments

- Supplemental payment to cover incremental costs of certain drugs, biologicals, and medical devices
- Goals: Accelerate payment for new technologies and ensure payment for new technologies not in data used to set payment rates
- Added payment for 2 to 3 years, then costs incorporated into relative weights
- Payment based on average wholesale price for drugs/biologicals and reported costs for medical devices
- Budget neutral with cap of 2.5% of total payments

Outlier payments

- Provide partial compensation for services that are extremely costly
  - Target of 2 percent of total payments
  - Budget-neutral implementation
- A service is eligible for payment if costs exceed 2.75 times the APC payment
- Additional payment of 45 percent of costs above the threshold

Transitional corridor payments

- Soften transition through additional payments to hospitals receiving lower payments than they would have under previous payment policies
  - All hospitals experiencing losses receive additional payments to make up some of the loss, 2000-2003 (those profiting keep gains)
  - Rural hospitals with 100 or fewer beds "held harmless," – all losses are made up – 2000-2003
  - Cancer and children's hospitals permanently "held harmless"

Payment for computerized axial tomography (APC 283), 2003 in DC

- Relative weight: 4.5057
- Conversion factor: $52.151
- Wage index for DC: 1.0851 (applied to 60%)
- Formula:

  (.40) x 4.5057 x 52.151 +

  (.60) x 4.5057 x 52.151 x 1.0851 = **$247**
- Possible adjustments:
  - Transitional corridor payment
  - Outlier payment

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Payment for pass-through service: echocardiogram (0671) with contrast material (9016), 2003 in DC

- Relative weight (0671): 2.3643
- Contrast material has pass-through status
- Formula for base payment:

  (.40) x 2.3643 x 52.151 + (.60) x 2.3643 x 52.151 x 1.0851 = $130
- Additional payment for contrast material:

  $118.75 (95% of average wholesale price)
- Total payment = $130 + $118.75 = **$248.75**
- Possible adjustments: transitional corridor, outlier

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Beneficiary coinsurance

- Coinsurance represents a higher share of total payments for outpatient services than other Part B services
- Coinsurance represented about 43% of total payment in 2001 ($6.8 billion)
- OPPS reduces coinsurance liability to 20 percent over decades

Buy-down mechanism

- Coinsurance amounts set at 20 percent of median **charges** in 1996 and frozen
- Payment rates updated annually
- When coinsurance equals 20 percent, coinsurance amount also increases
- New services have coinsurance of 20 percent
- Dollar amount capped at inpatient deductible ($840 in 2003)

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Coinsurance rate by type of service, 2001

	Procedures	Visits	Ancillary services	Pass-through items	Separately paid drugs/blood
% of payment:	70%	10%	10%	8%	1%

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Key issues

- New technology payments
- Volatility in payment rates, 2001-2003
- Beneficiary coinsurance
- Ending of transitional corridors

New technology payments

- Outpatient PPS was first to have explicit mechanisms to cover new technology
  - Pass-through payments
  - New technology APCs
- Issues with pass-through payments
  - Criteria for eligibility
  - Payment mechanisms
  - Maintaining budget-neutrality
  - Incorporation into the payment system once eligibility is ended

Volatility in payment rates

- Considerable swings in payment from 2001 to 2002 and from 2002 to 2003
- Problem of transition?
- Role of pass-through technologies
- Methodological issues
  - How hospitals bill for services
  - How hospitals set charges
- Probably less volatile in future

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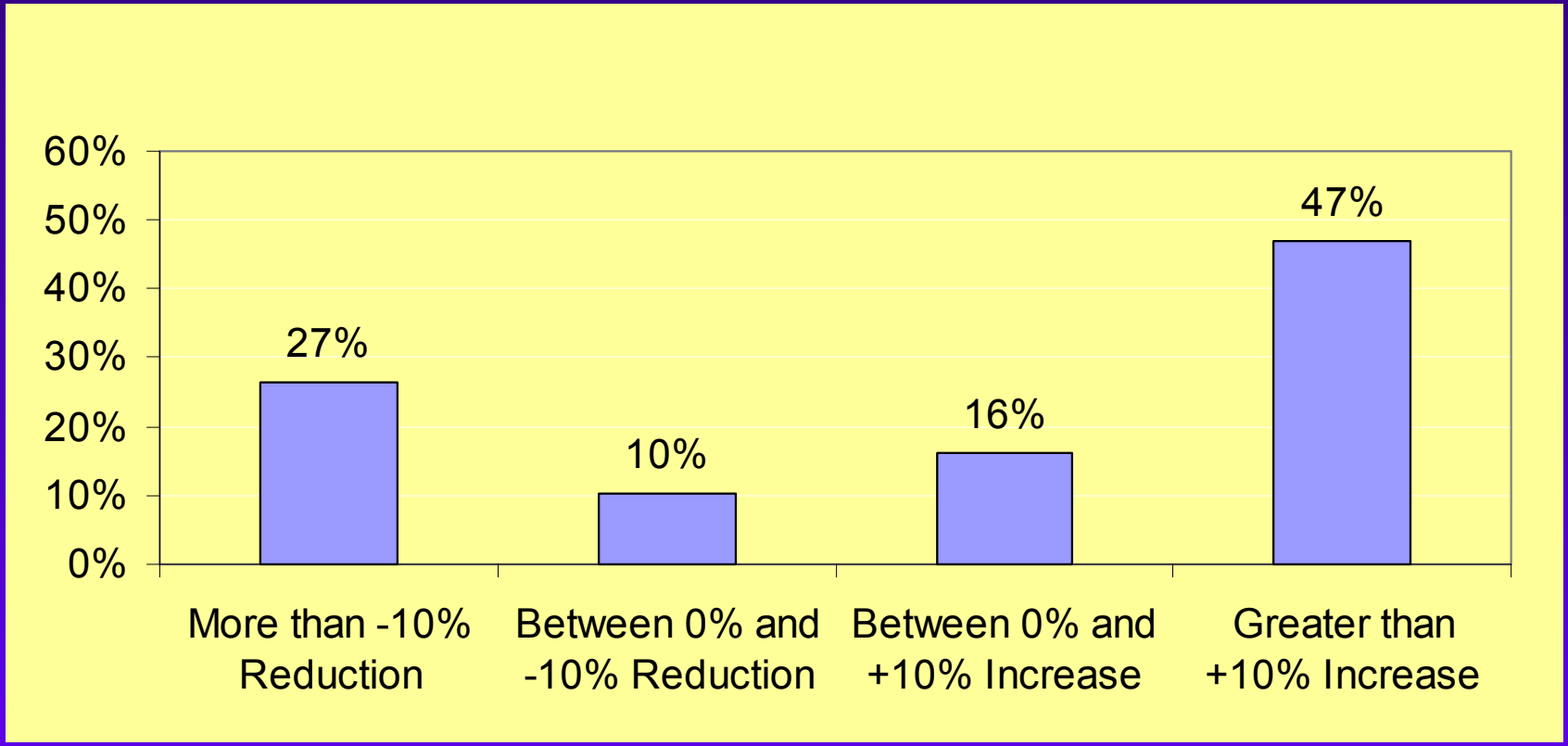
Swings in payment 2002-2003 by number of APCs (final rule)



Source: CMS

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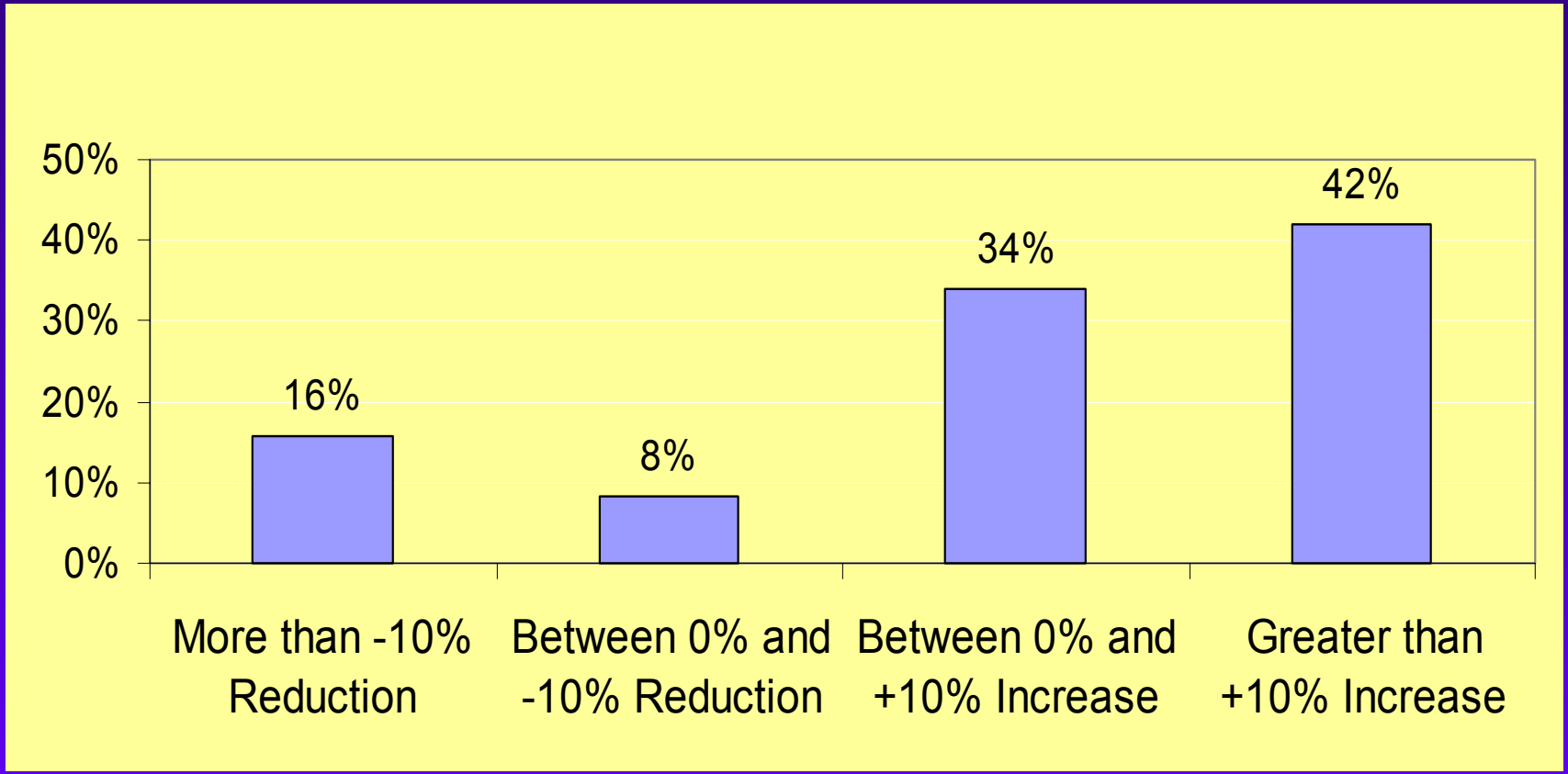
Swings in payment 2002-2003 by share of payments (final rule)



Source: CMS

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Beneficiary coinsurance

- Current law decreases the limit on coinsurance by 5 percentage points each year, stopping at 40 percent in 2006 and beyond
- Services with coinsurance of 40 percent in 2006 will take an additional 23 years to "buy down," assuming a 3 percent update
- All fixes are expensive

Ending of transitional corridors

- 2003 is last year of transitional corridors for most hospitals
  - Margins in 2000 show some improvement over 1999
- Small rural hospitals may be of special concern
  - Limited data on performance
  - Lower volume
  - Lower-intensity service mix